Montana Medicaid CLAIM JUMPER

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First PASSPORT Summit this Month

The first PASSPORT To Health Summit will be held on Tuesday, April 26 in Helena at the First Presbyterian Church. Registrations are still being accepted for those who want to participate in this key opportunity to affect change in the program. The meeting will begin at 10:00 am and will conclude at 4:30 pm. Refreshments will be served at 9:30 am; lunch will be provided.

The dates and locations of the other summits have also been finalized. They are: Havre on May 10 at Northern Montana Hospital; Billings on May 18 at MSU-B; Kalispell on June 8 at Kalispell Regional Medical Center; and Missoula on June 15 at St. Patrick's Hospital.

The goal of the meetings is to determine if the current operation of the PASSPORT To Health program is the most effective way to meet its objectives. Some of the issues that will be discussed at the summits include:

- What's the best way to assure our clients have a medical home?
- Is there a better way to assure that only appropriate care is provided to control costs?
- If a referral system is the most effective way to meet our objectives, how should the Department ensure that a PASSPORT referral number is secure?
- How can we assure adequate access to primary care for our clients?

For more information regarding the PASSPORT To Health Summits, visit our website at www.mtmedicaid.org or contact PASSPORT Program Officer Niki Scoffield at (406) 444-4148 or niscoffield@mt.gov. For those who plan on attending, an RSVPs to Niki is requested and greatly appreciated.

Billing for MHSP Services

Mental health services for adults ages 18 and over who are covered by the Mental Health Services Plan (MHSP) must be provided by designated mental health care centers or by a provider who is under contract with such centers. Claims submitted directly by the provider will be denied. Pharmacies may bill MHSP directly. If you have any questions concerning MHSP, please contact Charlie Williams at the Mental Health Services Bureau at chwilliams@mt.gov or (406) 444-1955.

CMS-1500 Tips

As a reminder, fields 9 and 11 on the CMS-1500 claim form should remain blank unless the client has third party liability (TPL). Medicare information should not be entered here either as Medicare is not considered TPL.

When third party coverage pays for a portion of a service, there is no need to send an attachment with your claim. However, if TPL denies the claim or the entire allowed amount went toward the deductible, a copy of the denial should be sent as an attachment to the claim you send to Medicaid.

Use field 19 on the CMS-1500 form for indicating that services are not related to workers compensation or are services for a Hutterite client or a Colony client.

All claims must have an authorized signature and date or the claim will be returned to the provider. The signature may be hand written, typed, stamped or computer generated.

See your provider manual for additional information on completing a paper claim including examples.

Nurse First: Three Distinct Programs

Nurse First is currently comprised of three components. They are: the Nurse First Advice Line, Nurse First Disease Management Services, and the Team Care Program. All Medic-

aid clients are eligible for the Nurse First programs, with the exception of nursing home and institutionalized clients, and those clients enrolled in Medicare where the State is paying the client's Medicare B premium.

Nurse First Advice Line

This service is a toll-free nurse advice line staffed by licensed registered nurses around the clock, seven days a week. Medicaid clients are encouraged to call the nurse line anytime they are sick, hurt, or have a health concern. The nurses triage the caller's symptoms and provide a recommendation to an appropriate level of care. These recommendations range from self-care at home to visiting the emergency room. Clients are asked not to call the nurse line for follow-up care including referrals to specialists, and for immunization appointments.

In addition to helping clients and reducing costs, the Nurse First Advice Line benefits physicians and other providers by: directing patients to an appropriate level of care; educating patients on how to prudently use the resources of the provider's office; and reducing provider call traffic and no-show rates.

Nurse First Disease Management

These services are designed to improve the overall health of Medicaid clients with chronic health conditions, and to reduce their medical costs. Nurses work telephonically and/or face-to-face with clients to promote adherence to providers' treatment plans and to help clients manage their own health through better self-care. The conditions currently managed are asthma, diabetes, chronic heart failure, cancer and chronic pain.

Team Care

This program is designed for Medicaid clients with a history of over-using health care services when there is no underlying medical necessity. These clients need additional assistance when accessing care. Team Care clients receive enhanced education and strict case management, ensuring they receive "the right care at the right time at the right place." Enrollment in the program is mandatory for identified clients and continues for a minimum of 12 months.

Team Care clients continue to receive the care they need; however, they are "restricted" to certain providers. These clients are mandated to enroll in the PASSPORT to Health program, select a primary care provider (PCP) to manage their care, receive all Medicaid-payable prescriptions from a single "lock-in" pharmacy, and call the Nurse First Advice Line prior to accessing care, even from their PCP.

For questions regarding the Nurse First Programs, contact Tedd Weldon in the Managed Care Bureau at (406) 444-1518, e-mail him at teweldon@mt.gov, or visit our website at www.mtmedicaid.org.

Submitting Denial Information Obtained from BlueCross Website

Providers may submit denial information obtained from the BlueCross BlueShield website to Medicaid with the claim. The denial information must include the complete denial message code **and** the explanation of the message code. Medicaid will deny claims without the required information.

When downloading the denial information from the website, you may need to print landscape in order to display the required information.

Electronic Billing

Did you know that claims that are submitted electronically can be processed in one day? Paper claims take about 20 days to get entered into the system. Also, providers that receive electronic remittance advices and electronic funds transfers can be reimbursed on a weekly cycle. Medicaid does not charge a fee for electronic submission.

For information on how you can convert to electronic claim submission, contact Bridget Martin with ACS at bridget.martin@acs-inc.com.

WINASAP 2003 Claim Status Function

Providers using WINASAP2003 to submit electronic claims can receive notification that their claims were successfully transmitted through the ACS clearinghouse. Once claims are sent to the clearinghouse, they will show a *Billed* status. Within a few minutes (maybe longer during peak times), you may retrieve your response file. The response file will change the claim status from *Billed* to *Accepted*, *Rejected* or *Errored* by the clearinghouse. For claims with a *Rejected* or *Errored* status, contact ACS EDI Technical Support at 1-800-624-3958.

The instructions for receiving your response file are as follows:

- From the WINASAP2003 Main Menu, select the *Tools* option.
- Select the *Receive Response File* option. This will open the *Receive* window.
- Click on the *Receive* button.
- WINASAP2003 will now dial your modem and receive the response, which is called a 997 or 824. Once the response is received, the claim status will change to either *Accepted Rejected or Errored*.

Optical Character Recognition Tips

On March 28, 2005, ACS will begin Optical Character Recognition (OCR) of all CMS 1500 claim forms, including professional crossovers. During this process, information from paper claims is read into OCR software and converted into an electronic format, resulting in quicker and more accurate processing. Claims that pass through the OCR software without edit will be paid more quickly than claims that do not meet necessary criteria. For successful, timely passage through the software, observe the following tips:

- Use an original, standard red-dropout form (CMS-1500, UB-92, etc.)

- Use machine (typewritten) print
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim

See the May Claim Jumper for more tips on how to take advantage of OCR technology to improve the speed and accuracy with which your claims are processed.

Pricing Logic Changes for Professional (CMS-1500) Claims

As many providers know, the Medicaid claims system has been under and overpaying on some claims that contain more than one modifier. We have corrected the Medicaid claims system effective April 1, 2005. Claims prior to this date will be adjusted. A notice will be posted to the website when effective dates have been determined. The changes are as follows.

Modifier Pricing. All three modifiers will now be considered in the pricing calculation for each line. Previously only the first two modifiers were considered for pricing. We have also updated our modifier grouping logic to allow all appropriate combinations of modifiers to be billed together on one line, and to deny inappropriate modifier combinations. With these changes, modifier pricing will be in line with correct coding and reimbursement guidelines. Providers should note this system change may result in lower allowed charges in some cases.

By-Report Pricing. When a line is priced using "by report" reimbursement, meaning the procedure code or one of the procedure code modifiers is reimbursed using "by report" logic, the individual provider percent reimbursement will be taken. For "by report" procedures or modifiers, 90% of physician reimbursement will be applied to mid-level practitioners, therapists, and schools, 62% of physician reimbursement will be applied for mental health providers and 125% of physician reimbursement will be applied for psychiatrists (ARM 37.86.205).

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from the Provider Information website at www.mt-medicaid.org. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website		
Date	**Provider Type**	**Description**
Notices		
03/09/05	Hospital Inpatient and Outpatient, ASC, Physician, Mid-Level Practitioners, RHC, FQHC and IHS	Notice regarding hysterectomy acknowledgement changes
Fee Schedules		
02/25/05	DMEPOS	Updated January fee schedule
02/25/05	Hospital Outpatient	Updated January fee schedule
03/08/05	Physician, Mid-Level Practitioner, Public Health Clinic, Podiatrist	Updated January fee schedule
Other Resources		
02/14/05	Pharmacy	Updated February drug class reviews, preferred drug list , preferred drug quicklist and rollout schedule
02/16/05	All Providers	PASSPORT To Health and Claim Jumper newsletters
02/16/06	Pharmacy	Updated preferred drug list
02/18/06	Pharmacy	Updated preferred drug list
02/22/05	Pharmacy	Updated preferred drug quicklist, March drug class reviews, draft drug list and agenda for Medicaid DUR board formulary committee Meeting on March 23rd
03/01/05	Pharmacy	Updated preferred drug quicklist
03/01/05	Team Care	Team Care and MEPS article from January Claim jumper
03/09/05	Hospital Inpatient and Outpatient, ASC, Physician, Mid-Level Practitioners, RHC, FQHC and IHS	Manual replacement pages regarding hysterectomy acknowledgement changes

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Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
Provider Relations, EDI Help Desk and PASSPORT
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
Prior Authorization
DMEPOS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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